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ABSTRACT

The purpose of this paper is to encourage state and local family and youth organizations, mental health agencies, education entities and schools across the nation to enter new relationships to achieve positive social, emotional and educational outcomes for every child. This paper offers recommendations and encouragement to family and youth organizations, state mental health and education leaders for policy development and changes needed to move toward systemic collaboration to coordinate and integrate programs and services. The aim is to align systems and ensure the promise of a comprehensive, highly effective system for children and youth and their families. Three appendixes are included on the development of the concept paper, resources for mental health in schools, and the dimensions of an accountability framework. (Author)

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MENTAL HEALTH, SCHOOLS AND FAMILIES WORKING TOGETHER FOR ALL CHILDREN AND YOUTH: *TOWARD A SHARED AGENDA*

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A Concept Paper

The National Association of State Mental Health Program Directors
and The Policymaker Partnership for Implementing IDEA at
The National Association of State Directors of Special Education

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IDEAs that Work
U.S. Office of Special Education Programs

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A Concept Paper

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FOREWORD

This Concept Paper is an initiative funded by the Office of Special Education Programs (OSEP) through the Policymaker Partnership with the support of two national organizations: The National Association of State Mental Health Program Directors (NASMHPD) and The National Association of State Directors of Special Education (NASDSE).

The U.S. Department of Education Office of Special Education Programs (OSEP)

OSEP is dedicated to improving results for infants, toddlers, children and youth with disabilities, ages birth through 21, by providing leadership and financial support to assist states and local districts. OSEP administers the Individuals With Disabilities Education Act (IDEA). IDEA authorizes formula grants to states, and discretionary grants to institutions of higher education and other non-profit organizations to support research, demonstrations, technical assistance and dissemination, technology and personnel development and parent-training and information centers. These programs are intended to ensure that the rights of infants, toddlers, children, and youth with disabilities and their parents are protected.

Policymaker Partnership (PMP)

PMP/NASDSE is one of four linked partnership projects funded by the United States Department of Education's Office of Special Education Programs. The projects are designed to deliver a common message about the 1997 landmark amendments to the Individuals with Disabilities Education Act (IDEA) to policymakers, local administrators, service providers and families and communities.

The National Association of State Mental Health Program Directors (NASMHPD)

Members are the Commissioners or other top administrators of state mental health programs throughout the country and territories. The purposes of the organization include providing a forum for state leaders in mental health services to share information and ideas, delivering state-to-state technical assistance to its members, developing policy recommendations, and advocating on behalf of its members and those persons the members serve. One of the five divisions of NASMHPD is its Division of Children, Youth, and Families. Made up of state-appointed children's mental health adminis-

trators, this group advises NASMHPD on all matters concerning mental health issues relating to children and youth.

NASMHPD is one of eleven primary partners in the Policymaker Partnership (PMP). This Concept Paper is the first product of an initiative that brings these two organizations together to forge stronger partnerships between state public mental health systems and state education systems.

The National Association of State Directors of Special Education (NASDSE)

The National Association of State Directors of Special Education, Inc. (NASDSE) promotes and supports education programs for students with disabilities in the United States and outlying areas.

NASDSE operates for the purpose of providing services to State agencies to facilitate their efforts to maximize educational outcomes for individuals with disabilities. Its official membership is made up of the state-designated directors of special education.

The National Association of State Directors of Special Education (NASDSE) is the host organization for the Policymaker Partnership.

Purpose of this Concept Paper

The purpose of this paper is to encourage state and local family and youth organizations, mental health agencies, education entities and schools across the nation to enter new relationships to achieve positive social, emotional and educational outcomes for every child. This paper offers recommendations and encouragement to family and youth organizations, state mental health and education leaders for policy development and changes needed to move toward systemic collaboration to coordinate and integrate programs and services. The aim is to align systems and ensure the promise of a comprehensive, highly effective system for children and youth and their families.

How the Concept Paper Was Developed

In late summer 2000, discussions began between the Policymaker Partnership at the National Association of State Directors of Special Education (PMP/NASDSE) and the National Association of State Mental Health Program Directors (NASMHPD) on how the two entities could collaborate to promote closer working relations between state mental health and education agencies, schools and family organizations on behalf of children. In late 2000, the sponsoring associations hired a consultant to oversee a joint project. NASMHPD and PMP/NASDSE decided that the first step in this project would be to develop a Concept Paper for policymakers at the state and local levels to lay the groundwork for building partnerships to address the social-emotional and mental health needs of all children.

A work group was formed of over thirty (30) experts from mental health, education and family support and advocacy groups to advise in the development of the Concept Paper. Over the months, that group expanded to over forty (40) members. Work group members participated in monthly conference calls and held two face-to-face meetings from January through July to provide guidance and advice. They reviewed various drafts of the document.

In October 2001, the Concept Paper was submitted to NASMHPD and PMP/NASDSE for endorsement and dissemination. Activities following the dissemination of the Concept Paper will include presentations of the findings and recommendations of the paper at national conferences and other venues before a wide variety of audiences who have an interest in this work. Other activities may include identifying and publicizing states or localities already practicing the values, beliefs and strategies promoted in the Concept Paper, bringing focus and support to this issue at state and national policy academies, legislative conferences and other policy meetings and providing or brokering technical assistance to states and communities interested in developing a shared agenda on behalf of all children and youth in public settings and their families.

A Vision for a Shared Education and Mental Health Agenda

Schools, families, child-serving agencies, and the broader community will work collaboratively to promote opportunities for and to address barriers to healthy social and emotional development and learning. The project's aims are to ensure that:

- All children and youth (including infants, toddlers, and preschoolers) have an equal opportunity to develop to their fullest cognitive, social, and emotional capacities; and
- The needs of those who experience psychosocial problems and emotional and behavioral disabilities are effectively addressed.

Schools, families, child-serving agencies, and the broader community will be continually involved in shaping policies, practices and strategies to develop comprehensive, multifaceted, and cohesive approaches that encompass systems of:

- Positive development of children (including infants, toddlers, and preschoolers), youth, families, and communities, and prevention of problems;
- Early identification — interventions for children (including infants, toddlers, and preschoolers) and youth at risk or shortly after the onset of problems; and
- Intensive interventions.

Such approaches will be integrated and will not only meet the needs of children and youth, but will also help strengthen the nation's families, schools and neighborhoods.

Mental Health, Schools and Families Working Together for All Children and Youth: *Toward a Shared Agenda*

Executive Summary

The challenges of the 21st century demand collaboration across groups to assure both achievement and well being for America's children and youth. Public mental health and education agencies, schools and family organizations must work together to meet the positive social, emotional and educational needs of every child. Schools urgently need a broad range of mental health programs and services, including strategies for building a supportive school environment, strategies for early intervention, strategies for intensive intervention and a framework for trauma response. These needs have been evident and are well documented in a series of national reports. The critical natures of these efforts are underscored by the events of September 11, 2002.

This paper encourages and offers recommendations to policymakers for systemic collaboration. The emphasis is on developing a shared agenda for children's mental health in schools. The aim is to create and sustain comprehensive, multifaceted approaches to social and emotional development, problem prevention, and appropriate interventions for mental health concerns. The goal is to support both well being and achievement in America's children and youth.

This document describes key characteristics of state mental health and education agencies and family organizations and highlights the rationale for partnerships for a shared agenda to accomplish agreed upon outcomes. Each potential partner brings to the enterprise both assets to build upon and challenges to overcome.

As a foundation for developing a shared agenda, a conceptual framework for meeting the social-emotional and mental health needs of all children is outlined. The framework encompasses a continuum of interventions, including the following:

- Positive development of children (including infants, toddlers, and preschoolers), youth, families, communities, and prevention of problems;
- Early identification — interventions for children (including infants, toddlers, and preschoolers) and youth at risk or shortly after the onset of problems; and
- Intensive interventions.

This conceptual framework will provide the basis for clearly articulated policies and should drive the development and implementation of a shared agenda that yields a continuum of systematic interventions. By providing a full continuum of efforts, students will receive the kind of support to build their academic and interpersonal resources. By delivering appropriate interventions earlier, fewer children may ultimately need complex, intensive and expensive interventions.

This paper includes strategic recommendations for action that incorporate phases of systemic change. These recommendations emphasize readiness for change and durable partnerships. This document encourages the following next steps:

1. NASMHPD and NASDSE should work through the Policymaker Partnership and the IDEA Partnerships to lead a pilot effort that affiliates states committed to a shared education/ mental health agenda.

2. NASMHPD and NASDSE should establish and maintain a cross sector national advisory body that includes researchers, practitioners, technical assistance providers and family members.

3. NASMHPD and NASDSE should convene teams from interested states to learn from each other and collectively pursue promising practices including:

   - Ways in which the states may identify blended and braided resources;
   - "Change agent" mindset throughout the cross-sector teams;
   - "Bridge building" strategies that link the state agencies with local agencies;
   - Strategies for creating durable partnerships, including alignment of missions, policies and practices across agencies, shared accountability, resource mapping, redeployment of existing resources, and action planning;
   - Methods to facilitate communication, coordination, problem solving, and sharing of lessons learned;
   - Personnel preparation systems that ensure that all personnel are well trained for their roles;
   - Capacity building efforts, including cross-training, that have potential to move the shared agenda beyond demonstration sites and develop efforts at scale across the states; and
   - Strategies that promote leadership across systems at all levels.

4. NASMHPD and NASDSE should engage key researchers, technical assistance providers, and family organizations in making and sustaining change.

Achieving the promises of this shared agenda requires true commitment. Partners must believe that the payoff in better outcomes for children, youth and their families is worth the investment of time, energy and money.

A number of highly successful state and community initiatives demonstrate that such investments are indeed worthwhile. Given the promise of enhanced partnerships, it is time to align policy and practice across agencies and move forward with a shared agenda.

Mental Health in Schools: A Definition

The Policy Leadership Cadre for Mental Health in Schools in a recent publication on school mental health, points out that discussions of mental health usually focus on "mental illness, disorders, or problems." Moreover, there is a strong tendency to define emotional and behavioral problems as "disorders." This deficit-based definition is only part of the picture. The authors of the Cadre document refer to the vision statement at the beginning of the Report of the Surgeon General's Conference on Children's Mental Health *(2000), which states: "Both the promotion of mental health in children and the treatment of mental disorders should be major public health goals." They point out that the term "mental health in schools" should "encompass considerations of the school's role related to both positive mental health (e.g., promotion of social and emotional development) and mental health problems (psychosocial concerns and mental disorders) of students, their families, and school staff." (Policy Leadership Cadre for Mental Health in School (2001), pp. 5-6).*

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INTRODUCTION

Many children and youth experience difficulties in gaining the social, personal, educational and vocational skills needed to succeed in our society. This paper offers recommendations and strategies to policymakers at all levels of government to help transform the two state-operated, child-serving systems that often do business as separate entities. As well, this paper challenges public systems to engage family organizations in a meaningful relationship that better meets the social-emotional and mental health needs of all children.

This kind of partnership requires policymakers and family organizations to develop and embrace a shared agenda for a coordinated and comprehensive approach to mental health service delivery. This approach encompasses proactive social and emotional development and prevention programs, early identification of and interventions for children at risk of developing emotional problems and intensive interventions and services for students with serious disturbances.

Before exploring the notion of a shared agenda among family organizations, state mental health and education agencies and schools, this paper reviews prevalence data about mental health problems that affect children and youth.

Next, the paper describes both the similarities and unique differences among family and youth organizations and the mental health and education systems. Some of these differences present real challenges to effective collaborations. However, these three potential partners also share many similar goals for children, youth and their families:

- ☐ They hold similar values, beliefs and ideals;
- ☐ They all face difficult challenges in fulfilling those ideals; and
- ☐ They all bring assets and strengths to partnerships designed to work more effectively on behalf of children and youth.

The third section of this paper describes the conceptual shifts in thinking and behavior that will be required to establish a shared agenda that potential partners can create to improve academic, social-emotional and mental health outcomes for all children. It articulates a seamless, fluid, interlinked multi-level framework that encompasses positive child and youth development, prevention, early intervention and intensive interventions.

The fourth section offers recommendations for action to family, mental health and education policymakers to develop partnerships to meet the social-emotional and mental health needs of all children, youth and their families.

The fifth section summarizes the critical need for collaboration. As well, this section emphasizes the will necessary to sustain a commitment and achieve the desired goals.

1 The Current Mental Health Status of Children and Youth in State Mental Health Systems and Public Schools

In developing a shared agenda, potential partners must grasp the prevalence of mental health problems affecting our children and youth. What proportion of our children and youth experience the most severe and debilitating disturbances? After reviewing the existing research literature, authors of the Surgeon General's 1999 Report on Mental Health concluded that "one in five children and adolescents experiences the signs and symptoms of a DSM-IV disorder during the course of a year."

> *In 1993, the federal agency, the Center for Mental Health Services within the Substance Abuse and Mental Health Services Administration (SAMHSA) defined "Serious Emotional Disturbance" (SED):*
>
> *Children with a Serious Emotional Disturbance are persons:*
>
> - *from birth up to age 18*
> - *who currently or at any time during the past year*
> - *have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM III-R [and subsequent revisions, and the current version of the ICM]; and,*
> - *that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities*
>
> *Federal Register*, May 20, 1993, p. 29425

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A national study has not been conducted to examine the prevalence of SED among youth. However, in 1996 Friedman and his colleagues analyzed the results of studies that examined the prevalence of SED in a variety of communities. This investigation concluded that approximately 20 percent of all children and youth have a diagnosable mental disorder.

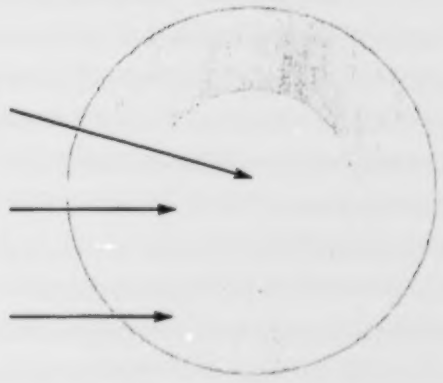
Friedman and colleagues further delineated the estimated range of children who experience an emotional disorder into two smaller groups based on the amount of impairment associated with the disorder. While 20 percent of all youth may experience a diagnosable emotional disorder, 9-13 percent of these youth will experience a serious emotional disturbance with substantial functional impairment, of that number, 5-9 percent will experience a serious emotional disturbance with extreme functional impairment. Further, Friedman asserts that poverty levels and other measures of low socio-economic status may affect the number of children with emotional disorders and he advises communities with these characteristics to use the high end of the ranges provided to estimate prevalence of youth with emotional disorders.

The 1999 Surgeon General Report on Mental Health seems to corroborate the Friedman estimates in reporting that approximately one in five children and adolescents experiences signs and symptoms of a diagnosable disorder during the course of one year, but only 5% of all children experience "extreme functional impairment". Today, the Center for Mental Health Services (CMHS) still refers to the Friedman study in assisting states to begin planning for services by determining prevalence rates for children and youth with emotional disorders.

Prevalence of Serious Emotional Disturbance (9 to 17 year-olds)

Population Proportions

5 – 9%	*Youth with serious emotional disturbance & extreme functional impairment*
9 – 13%	*Youth with a serious emotional disturbance, with substantial functional impairment*
20%	*Youth with any diagnosable disorder*



"Population Proportions", Friedman, et. al, Chapter 6, *Mental Health, United States, 1996*, p. 83.

Likewise, The Policy Leadership Cadre for Mental Heath in Schools, a group of experts under the auspices of the Center for Mental Health in Schools at UCLA notes that large discrepancies exist across socio-economic levels. They reviewed a number of school and mental health data reports and concluded that the number of students with psychosocial problems "in many schools serving low-income populations has climbed over the 50 percent mark, and few public schools have fewer than 20 percent who are at risk." (Policy Leadership Cadre for Mental Health in Schools, 2001, p. 2).

How Many Children in Schools Receive Services for Emotional Disturbance?

Schools determine special education eligibility for children experiencing "emotional disturbance" using somewhat different criteria than the Center for Mental Health Services uses for "SED."

> *The regulations of the Individuals with Disabilities Education Act Amendments of 1997 define "emotional disturbance" as follows:*
>
> *(Note: this definition may change with reauthorization projected for 2002.)*
>
> *300.7 (c)(4) Emotional disturbance is defined as follows:*
>
> *(i) The term means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance:*
>
> *(A) An inability to learn that cannot be explained by intellectual, sensory, or health factors.*
>
> *(B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.*
>
> *(C) Inappropriate types of behavior or feelings under normal circumstances.*
>
> *(D) A general pervasive mood of unhappiness or depression.*
>
> *(E) A tendency to develop physical symptoms or fears associated with personal or school problems.*
>
> *(ii) The term includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance.*

The U.S. Department of Education reported that during the 1998-1999 school year, more than 463,000 children ages 6-21 with emotional disturbances were served in the public schools nationwide. These are only those students who were identified under the Individuals with Disabilities Education Act (IDEA), Part B, under the category of Emotional Disturbance. (U. S. Department of Education, 2000.) An additional undetermined number of children with psychosocial, emotional-behavioral or severe mental health problems are also served under other disability categories, such as "Other health impaired" and various learning disabilities. In addition, there are other students receiving mental health services in schools who are not categorized as disabled under the provisions of IDEA. Even so, the percentage of students with serious behavioral or emotional disabilities who receive mental health services is extremely low. According to a number of experts, at least as many as 3-5 percent of school children are considered to have serious behavioral or emotional disabilities that require intensive coordinated services; however, it is estimated that less than 2 percent of these students receive any mental health services (Hoagwood and Erwin, 1997). For youth in the juvenile justice system the picture is even worse. The prevalence of youth with emotional disabilities is estimated to be at least three to five times greater in juvenile correctional facilities than in public schools (Leone and Meisel, 1997).

II. Mental Health in Schools: Rationale for a Shared Agenda

Delivering mental health programs and services in the schools is not a new idea. Examples of existing practices include informational presentations to groups on specific mental health topics, consultation and training for teachers and other school personnel, psychoeducational assessment, individual and group therapy, one-on-one aides or mentors in the classroom for students with emotional problems, crisis intervention, post-trauma counseling, social skills training and much more. We have much to learn from these current efforts as we move to develop a shared agenda.

Most schools already employ staff with mental health expertise that offer an array of interventions. These personnel include school counselors, school psychologists, school social workers, nurses and special educators. Some school districts hire other mental health professionals specifically to serve students with serious emotional-behavioral difficulties. In effect, schools constitute one "system" for addressing the mental health concerns of children and youth.

While states provide youngsters with public mental health programs and services primarily through a completely separate system, the systems connect when local or regional public mental health agencies offer interventions in schools. Typically, public mental health providers try to offer the same menu of services at schools as they do at their agency. These efforts usually are the result of local initiatives and not part of a statewide or even district-wide comprehensive plan to provide mental health services in schools. They quite often are "add-ons" intended to respond to immediate needs of the school or individual students.

In spite of the best efforts of school and mental health systems, families often experience great difficulty navigating the bureaucracy and red tape when seeking the early intervention programs and coordinated services their child needs. In order to have a positive impact on child-serving systems, some family members have learned to band together through membership in support and advocacy groups to gain influence in the places where important decisions are made about service policy and practices. However, most families whose youngsters might benefit from a range of mental health programs have relatively little opportunity to provide policy recommendations to school and mental health agencies.

Schools, state mental health systems and associations representing families operate within different organizational cultures. Thus, before considering the particulars of a shared agenda among these entities, it is important to clarify some key facets of each of them. Then, to further lay a foundation for this Concept Paper, we highlight (a) a rationale for developing a shared agenda, (b) the value of adopting a shared agenda, and (c) some anticipated assets and barriers facing the partners.

Descriptions of Three Potential Partners for Mental Health Programs and Services in Schools

Potential partners for mental health programs and services in schools need to know some basics about the organization, skills, program capacities, practices, and challenges each other's systems face. What follows are brief introductions to each entity.

Public Mental Health Systems

Orientation and Organization

Public mental health systems throughout the nation are primarily the responsibility of state government, not the federal government. State mental health programs and services are typically provided under the auspices of a separate entity, usually a cabinet or department that includes community and institutional services for adults as well. In some instances, the state mental health component for children is a part of the child welfare department or cabinet, which may also include juvenile justice and other human services. Moreover, in many states, the agency that holds authority for mental health services also maintains responsibility for substance abuse and services for persons with mental retardation or developmental disabilities. In some states, those functions are under the auspices of separate or different organizational entities.

Many states use local government or private, not-for-profit community mental health centers (CMHCs) as primary providers of public mental health services for both children and adults. Because of the autonomy that CMHCs enjoy, availability and accessibility to programs and services vary considerably from community to community. Communication about state efforts in this arena is facilitated across the states through the National Association of State Mental Health Program Directors (NASMHPD).

A state's public mental health program for children is often separate from that state's public education program. Although they often serve many of the same children, education and mental health systems operate under separate, and in many ways, different mandates, missions, philosophies, funding streams, goals and practices.

Historically, public mental health systems have been designed on a medical model that is deficit-based and divides treatment into outpatient services and inpatient care (including residential or hospital services). Up until fairly recently, the mental health professional's authority in all major treatment decisions was generally unquestioned and the role of the family was often ignored or considered detrimental to the child's well being. In the past ten or fifteen years, however, most public state and local mental health agencies have adopted a more family centered, community based model for children and their families. This approach stresses the importance of serving children in their own families and communities in ways that are strength based and in partnership with families. Rather than relying solely on outpatient and inpatient care, more agencies recognize the importance of developing a full array of services for children and their families, including service coordination, therapeutic foster care, in- and after-school programming, respite care, crisis stabilization, and other interventions and services.

Significant federal research and technical assistance have been made and targeted toward building relationships with family systems and developing school-based service continuum. In recent years, the U.S. Department of Health and Human Services has made significant invest-

ments in school health (including mental health). For example, the Centers for Disease Control and Prevention (CDC) have provided infrastructure grants to states interested in promoting coordinated school health programs. The Maternal and Child Health Bureau (through its Office of Adolescent Health) and the Bureau of Primary Health Care have provided funding for programs and for technical assistance and training centers to support school health (both physical and mental). The Substance Abuse and Mental Health Services Administration provides Safe Schools/Healthy Students grants that require mental health and education to coordinate services.

Mandates and Funding

True reform and more recognition of children's mental health systems on the federal level began to have impact on state policy and funding in the early 1980s. The major stimuli for these reforms have been (1) a relatively small federal grant program—the Child and Adolescent Services System Program (CASSP), and, (2) a number of other related initiatives funded by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services. As a result, almost every state and territory, at least in some of its communities, has begun to develop a more collaborative system of care for children and youth with severe emotional disturbances. The system of care framework that has nurtured these federal efforts stresses the importance of developing a wide array of community-based services that a child and family accesses through service coordination, usually guided by interagency and interdisciplinary teams. These services strive to be culturally responsive, child-centered and family focused and driven. Implementation of systems of care varies greatly from state to state. Evaluation findings are somewhat mixed, but overall suggest promising outcomes.

Federal law requires states to provide an array of services and the federal Center for Mental Health Services (CMHS) requires an annual plan for services to children and adults in order to receive federal block grant funding. Funding must target community-based services, not residential or institutional services, for both adults and children. However, these funds must be used by states to serve adults with severe mental illness and children with severe emotional disturbances.

Mental health block grants comprise a small portion of most state mental health agencies' budgets. Moreover, this funding carries no mandates, like those in federal child welfare laws that require the state to meet the needs of all children in its custody. Most state mental health services are delivered by county or regional community mental health centers that are governed by boards responsible for the fiscal viability of the organization. Most regional, county or local mental health boards are private, not-for-profit corporations. In order to maintain operations, these centers must work within their budgetary constraints. They cannot run a deficit and stay in business very long. Because there is no federal mandate, public mental health providers must limit both the types and amounts of services available to the general population.

Two other funding issues factor into the provision of public mental health services. First, since their inception, the federal children's mental health initiatives that began with CASSP have focused services solely on those children and youth with severe emotional disturbances (SED) and their families. Following the lead (and, more importantly, the funding) of the federal government, most state mental health agencies concentrate on addressing the needs of this population.

The other major funding issue in most states is that Medicaid is a major, if not the chief, source of funding of children's mental health services. Whether under Medicaid managed care, the rehabilitation option or any other Medicaid program, service funding is linked to a determination of "medical necessity" criteria for that individual child or youth. This requirement makes positive child and youth development programs, including parenting and formal programs that teach social and problem-solving skills; problem prevention programs and activities; and, some early intervention services, difficult to fund under Medicaid.

In a number of states, the public mental health agency partners with other state agencies to win federal and foundation grants for mental health-related issues, such as school safety, prevention initiatives of the Bureau of Maternal and Child Health, and other programs that require collaborative efforts among child serving agencies. Other states have designed collaborative service models that utilize federal CMHS children's mental health funds for children and youth with SED, while also participating in more comprehensive programming that includes prevention and early intervention efforts.

Schools and Mental Health Services

Orientation and Organization

Over the years, schools have been required to assume more and different responsibilities for children and youth, along with increased accountability for high achievement of all students. In order to ensure academic achievement, schools must also attend to students' health, well being and behavioral concerns. Deficits in social/emotional health and well being present serious barriers to learning for many children and must be addressed. At the same time, education personnel recognize that they alone are unable to meet all the needs of all their students.

Two of the most popular delivery methods are school-linked delivery and school-based delivery of services. There are many variations in configurations of multiple agency collaboration that provide and improve access to health services, specifically mental health services. They operate on a continuum of coordination, collaboration and integration. School-linked include various types of formal and informal arrangements across agencies and schools designed to meet mutual goals. School-Based services are located in a school or on school grounds and are designed to provide onsite preventive and direct services.

> *".....comprehensive systems-change initiatives are designed to create a seamless web of supports and services that "wrap around" children and families and to bring an end to the current fragmentation and categorical separation of school agency-directed programs."*
>
> *U.S. Department of Education. (2000). Twenty-second annual report to Congress on the implementation of the Individuals with Disabilities Education Act, p. III-9.*

Multiple agencies have invested and provided technical assistance to develop relationships among family, agencies and schools. The United States Department of Education, Office Of Special Education Programs (OSEP) follows a research-to-practice paradigm that supports the effective translation of research into improved practice. This paradigm has guided investment in Research, Technology, Training, Technical Assistance, Parent Training and Information Centers, Evaluation and State Improvement Grants. Mental health investments can be found in each of these areas including investments in specific topics such as positive behavioral interventions and supports, safe schools, effective mental health practices, school mental – health collaboration, and delinquency prevention and individuals with disabilities in the juvenile justice system.

The school board, superintendents, principals and other top administrators at the local level are the key decision-makers for schools. While there are varying levels of state and local oversight, local school districts have a great deal of autonomy. As a result, school districts' approaches and emphases, and even definitions of mental health programs and services, differ widely.

Depending on the resources of the school district, these interventions may be delivered by school staff, including school psychologists, counselors, social workers, nurses and special educators. School personnel are involved in promoting healthy social and emotional development and applying strategies and staff training for ensuring a safe and healthy school climate (including addressing discipline problems). They also work with students identified with severe emotional or behavioral problems. Some school districts contract with outside mental health providers for school-based or linked outpatient mental health services.

Local education agencies are able to seek information and assistance in effective school mental health planning through several national organizations, including the Council for Chief State School Officers, the National Association of State Boards of Education, the National Association of State Directors of Special Education and many other groups.

Mandates and Funding

Over the past 30 years, support for the provision of mental health services in schools has waxed and waned and currently is in a period of resurgence. In 1975, the passage of Public Law 94-142, now called the Individuals with Disabilities Education Act (IDEA), mandated services for students identified under 13 disability categories, each with specific identification criteria. It is commonly recognized that the sources of funding have not kept pace with request for services. This discrepancy has been a source of increasing tension between education, mental health agencies, and families and within the education establishment itself.

Several major public laws signed into law in the mid-nineties have added support to the movement to provide mental health services in schools. The Improving Americas' Schools Act and the Goals 2000: Educate America Act enacted in 1994 mandated development of a more comprehensive approach to meeting the needs of low achieving students. In 1997, the IDEA Amendments (P.L. 105-17) were enacted. Among other important provisions, IDEA 97 provides increased support for improvement grants through state education departments and for prevention and early intervention programming. It calls for functional behavioral assessments and behavioral intervention supports for students with disabilities experiencing behavioral and disciplinary problems. It also strongly promotes interagency agreements for the coordination and delivery of services from other public agencies that have responsibility for paying or providing needed services.

The recently enacted "No Child Left Behind Act of 2001" reauthorizes and amends the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6301 et seq.). One section, *"Subpart 14—Grants to Improve the Mental Health of Children, "Sec. 5541. Grants For The Integration Of Schools And Mental Health Systems,* addresses ".....student access to quality mental health care by developing innovative programs to link local school systems with the local mental health system". This subpart appears to hold promise for developing collaboration between schools and mental health agencies at the local level.

No Child Left Behind Act of 2001

> *Subpart 14—Grants to Improve the Mental Health of Children,*
> *SEC. 5541. GRANTS FOR THE INTEGRATION OF SCHOOLS AND MENTAL HEALTH SYSTEMS*
>
> *(c) USE OF FUNDS.—A State educational agency, local educational agency, or Indian tribe that receives a grant, contract, or cooperative agreement under this section shall use amounts made available through such grant, contract, or cooperative agreement for the following:*
>
> *(1) To enhance, improve, or develop collaborative efforts between school-based service systems and mental health service systems to provide, enhance, or improve prevention, diagnosis, and treatment services to students.*
>
> *(2) To enhance the availability of crisis intervention services, appropriate referrals for students potentially in need of mental health services, and ongoing mental health services.*
>
> *(3) To provide training for the school personnel and mental health professionals who will participate in the program carried out under this section.*
>
> *(4) To provide technical assistance and consultation to school systems and mental health agencies and families participating in the program carried out under this section.*
>
> *(5) To provide linguistically appropriate and culturally competent services.*
>
> *(6) To evaluate the effectiveness of the program carried out under this section in increasing student access to quality mental health services, and make recommendations to the Secretary about sustainability of the program.*

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Public funding from a variety or sources currently support research and training centers that enhance school mental health services. Two of these centers, the Center for School Mental Health Assistance at the University of Maryland Baltimore, and the Center for Mental Health in Schools at the University of California Los Angeles, have the broad-based enhancement of mental health in schools as their mission.

Federal investments are breaking new ground in cross-agency work. Increasingly, there are opportunities for state and local cross-agency collaboration drawing on the research and technical assistance provided by federal investments.

Families and Youth

For purposes of this paper, the family and youth component of the shared agenda refers broadly to groups or organizations made up of youth, parents and family members of children and youth who are in schools and who are concerned with enhancing systems for mental health. Family and youth organizations continue to have an ever-increasing impact on the public human service sector. This component consists of a diverse confederation of organizations, advocacy groups or associations. Organizations of this type should be considered equal partners with schools and other agencies in defining the shared agenda. Unless families and youth, through their organizations, are at the table in meaningful ways, any attempt to form an effective shared agenda will be severely compromised.

Families are defined broadly here. A family consists of minor children or youth, and their parents, primary caregivers, and others either legally or informally bound to one another. In addition to biological parents, family members may include foster parents, adoptive parents, grandparents, other relatives or friends who assume the parental, custodial, or other supportive role. In other words, the family defines its members by function rather than merely by birthright.

Orientation and Organization

Families and youth make up the largest stakeholder group—the consumers of, and advocates for, mental health programs and services. It is their collective voice that must be heard in formulating the vision for a single collaborative and coordinated system that meets the social-emotional, well being and mental health concerns of all youngsters.

Successful interagency partnerships make every effort to include family members in the decisions and actions that affect their own children. Parents and other family members are the experts on their own children, and, insofar as possible, they must be allowed, encouraged and supported to participate actively in every aspect of decisionmaking regarding their children. Many families also participate in decisionmaking around policy development or system and program planning, implementation and evaluation. Family leaders who have the trust and the support of other families in an organized group are empowered to speak and act on behalf of many families when important decisions are made.

Family and youth organizations certainly are not systems in the same sense that mental health and education are. Unlike state agencies, families and youth and their advocacy groups reflect widely varying missions and goals. Family organizations are often focused on specific aspects of child welfare, or specific conditions such as autism or Tourette's syndrome. Often, in order to have an impact on the larger system, family and youth organizations participate in larger state coalitions around broader issues of children's social and emotional well being.

Mandates and Funding

Most family support and advocacy groups do not enjoy the relatively stable public funding provided to public agencies. They are often dependent on federal, state, local or private grants, and on the voluntary participation of their members, many of whom are already coping with family challenges and stresses.

Few family and youth organizations that focus on children's mental health have a strong statewide voice; their issues and concerns are more often local and specific, and often their influence does not span the whole state as do state agencies. Their relationships to the various state agencies are often quite complex. As advocates for more and better services, they sometimes are supportive of, and are sometimes adversarial to, the agencies that serve children and youth—depending on the issue at hand. Being consumers of services, as well as advocates and partners with policymakers and providers, creates a unique tension that all involved must become adept at addressing and balancing.

Rationale for a Shared Agenda

Family and youth organizations, public education and state mental health systems share key values and goals. All want every child and young person to become a healthy, productive and caring citizen. All want safe and effective schools, homes and communities. All acknowledge the need to improve positive family participation and cultural responsiveness to families. Therefore, one major reason for pursuing a shared agenda is that all three parties already share many common values and goals.

Responsible, strategic use of limited resources demands a shared agenda. A well-planned and implemented agenda can be expected to do better in identifying needs and deploying resources, resulting in more comprehensive, integrated and cost-effective programs and services. A shared agenda also would foster enhanced accountability for public dollars. Particularly at this time of national crisis, we must pool our resources and coordinate our service planning to address the urgent mental health needs of children, youth and school personnel.

The complex and multiple needs of children facing significant mental health challenges cannot be met without a shared agenda. Currently, many children fall through the cracks as a result of too many specialized programs working in isolation. Successful outcomes—especially for children and youth with complex and multiple needs—depend on how well schools, mental health agencies and families work together. A shared agenda will help strengthen working relationships among all the partners, thereby ensuring that these children and youth receive the services and supports they need.

The timing is right to develop a shared agenda. Leaders of family and youth organizations and state education and mental health systems realize that no one system can adequately address the needs of all children. Moreover, the three potential partners all are in the midst of significant changes. More than ever, family voices include a variety of languages and cultural and ethnic backgrounds. At the same time, school and mental health reforms are creating more opportunities for interagency partnerships and integrated programs and services. The intersection of these forces create a push for change and opens the opportunity for developing a shared agenda.

The Outcomes We All Want

Any successful partnership is outcome-driven. For a collaborative effort of this sort to thrive and sustain, it must demonstrate positive outcomes for children and youth. Each of the partners already brings to the table a set of particular desired outcomes for children and youth and for each of their systems. In the very early stages of development of the shared agenda, partners must identify what their distinct sets of outcomes share in common, and build their partnership on this common ground. The ownership that the partners experience over this common set of outcomes nurtures mutual responsibility, a crucial dimension of successful collaboration. Academic achievement becomes not only the responsibility of the schools, but also of mental health agencies and family organizations. Children's social-emotional and behavioral well being becomes not only the responsibility of families and mental health agencies, but also of schools. Listed below are typical outcomes that partners might consider. This list is intended to be suggestive, not comprehensive.

Outcome for Children and Youth

- Academic achievement for all children and youth
- Improved readiness for learning (i.e., better attendance, grades, decreased discipline referrals, drop-out rates, etc.)
- Improved social and emotional functioning, with peers, teachers and family
- Improved skills for achieving economic self-sufficiency and independent living
- Improved mental wellness (including positive behavior, emotional intelligence and thinking and coping skills)
- Improved satisfaction with school by children and youth
- Greater involvement in decisionmaking

Outcome for Families

- Higher participation of families in all aspects of the school's mental health initiatives—from individual treatment planning to program planning and evaluation
- Enhanced family support
  - From peers
  - From school and mental health personnel
  - From the community
- Improved family satisfaction with school and mental health services
- Increased family access to sources of information
- Increased family access to community-based services
- Increased choices/options available to families

- Increased shared authority and accountability for all decisions affecting children and families
- Improved family relations

Outcome for Systems

- Safer and more effective schools as a result of a more supportive school culture and climate
- Better trained workforce with enhanced skills
- Improved personnel competence, job satisfaction and retention
- Improved coordination and compatibility between education and mental health approaches/services
- More efficient use of limited resources
- Cost efficiency: decreased costs, increased productivity and improved outcomes

Outcome for Communities

- Healthier and more productive citizens
- Improved quality of life for citizens
- Increased citizen contribution to community's welfare
- Fewer youth in juvenile justice system
- Decreased need for more intensive health care (e.g., reduced demands in public health facilities, psychiatric hospitals, residential treatment and substance abuse treatment)
- Decreased stigma, more acceptance of mental health services
- Decreased school suspensions and expulsions
- Increased after-school activities/involvement
- Raised awareness about youth mental health, the gap between needs and resources and a sense of urgency to do something about the problem
- Decrease in youth and community violence
- Better attention to people victimized and exposed to physical and other forms of violence
- Improved environment of community information-sharing, problem-solving and idea development that involves all the stakeholders

III. Moving Forward: Forging New Partnerships for a Shared Agenda

Building on Strengths; Dealing with Challenges

Key Assets of Each Partner

Family Organizations bring passion and knowledge based on practical, real-life experience. They understand their children's strengths and difficulties in coping with the stresses of growing up. Families and youth can provide the child-serving systems critical feedback on the accessibility and effectiveness of services. Not only are parents and other family members the real experts on their own children, they often, of necessity, become experts in navigating the systems. This is true of many youngsters as well.

Families and youth know what works and what does not work. Many organizations provide a strong family and youth voice. Thus, they are in a unique position to teach policymakers and providers about cultural competence and system responsiveness. They can also play a potent role in teaching practitioners about how to make their systems and services more family-friendly. In addition, they provide an invaluable base of support and assistance when families and young people are in crisis related to mental health or other concerns. Just as importantly, they provide advocacy training and leadership development for their members. Family members gain knowledge of the systems with which they are dealing and skills to participate productively in discussions of policy and practice.

Education agencies and schools represent a system of universal access for every child. In their responsibility to ensure high standards of achievement for every child, schools are exploring reforms leading toward creating learning environments that are responsive to a wider array of student learning needs. The field of education has discovered effective research-based structures and practices that offer behavioral supports and interventions to build school climates favorable to learning. These approaches encompass positive child and youth development, prevention of problems and early intervention strategies as well as addressing school climate and discipline. Many school administrators across the country have embraced a number of whole school approaches to build a healthy, safe and nurturing school environment and a positive school climate. Such approaches dramatically decrease disciplinary actions, visits to the principal's office, absences and tardiness and increase academic performance and positive interactions among students, teachers and between students and teachers. Additional funding

and support for preventing school violence has also provided schools with new and exciting resources that address proactive mental health promotion and early identification of at-risk children and youth and students who need assistance. Public schools, by their very nature, provide the most natural environment in which to offer students of all ages and abilities these kinds of assistance.

The state public mental health agencies in most states have made great progress in improving children's mental health services in the past fifteen years. Under CASSP, the system of care for children and youth with severe emotional disturbances emphasizes the importance of strength-based interventions, interagency collaboration, serving children in the least restrictive settings, family involvement, cultural competence and other key principles. For most states, a major incentive for developing a community-based system of care is to reduce the large number of unnecessary placements of children in hospitals and other large institutions. As this approach evolves, many state mental health authorities and public community mental health centers are learning how to work closely with other agencies and to involve family members in meaningful and important ways. Today there are more community-based services for children, youth and their families than ever before, including therapeutic foster care, day treatment, crisis stabilization, respite care and other non-traditional programs and interventions. Appropriate services and supports are "wrapped around" children and youth through service coordination (case management) and service teams for each child.

Not every state has adopted a system of care approach. It is sometimes not available statewide even in those states that have embraced the strategy. Nevertheless, the initiative has developed a rich research literature and technical assistance component. What we have learned about collaboration, family involvement, cultural competence and other aspects of mental health services for children reinforces and complements the work that the education system is doing in these areas. The public mental health system's strong emphasis on serving children and youth with severe emotional disturbances and their families is an important area for collaboration with schools.

Challenges to Developing a Shared Agenda

Policymakers from mental health and education agencies and family organizations face a number of major challenges in developing a shared agenda. These challenges, however, are not insurmountable. Most of them stem from, or reflect, the significant differences among the partners.

Mental Health And Education. While sharing many values and overarching goals, each agency has developed its own organizational culture, which includes a way of looking at the world, a complex set of laws, regulations and policies, exclusive jargon and a confusing list of alphabet-soup acronyms. Funding sources at the federal, state and local levels have traditionally reinforced this separation into "silos." The result is that agencies are almost totally isolated entities, each with its own research and technical assistance components and its own service delivery system, even though they are serving many of the same children.

The isolation of each agency, combined with its bureaucratic complexity, requires a long-term commitment of all partners to bridge the gaps between them. Collaborative structures must be based on a shared vision and a set of agreed upon functions designed to enable a shared agenda. Legislative, regulatory or policy mandates may help bring agency representa-

tives to the table, but development of true partnerships and the successful accomplishment of goals depends on participants gaining trust in one another as they pursue a shared agenda.

Family And Youth Organizations. Barriers to family involvement are well documented and require little elaboration here. Examples include professionals who view the family as the cause of the child's problem (parent blaming), who relegate parents and other family members to the subordinate role of client or hold the view that professionals always know best, or who are insensitive to family work schedules and other difficulties related to working as partners. With respect to family and youth organizations, probably the major barrier is the difficulty they have in speaking with a unified voice. As indicated earlier, family organizations are not a "system" in the same sense as are state mental health and education systems. However, to have major influence, family and youth organizations often need to coalesce. In successful partnerships, family organizations usually form coalitions with different associations and groups to enhance and represent their views.

As potential partners beginning to forge a shared agenda, agencies and organizations need to assess what each brings to the table and learn to build on each other's strengths and deal with the challenges of working together. Over time, it will help to identify such strengths and challenges in an organized way. To illustrate the point, some key examples of current strengths and challenges are offered below. They are organized with reference to specific arenas of activity that are relevant to fashioning a shared agenda. These include values, policy, funding and infrastructure as well as legal matters, advocacy, leadership and capacity building.

Creating a Shared Agenda: Current Strengths and Challenges

Values, Policy, Funding and Infrastructure

SOME MAJOR STRENGTHS:

- ☐ All potential partners share some core values and goals:
  - strong family participation in their children's schools and other agencies that serve them;
  - effective cultural responsiveness, better and more productive lives for children, youth and families; and
  - stronger and safer communities and schools.
- ☐ A number of federal agencies are offering grants that require interagency collaboration.
- ☐ Federal child-serving agencies are partnering to offer grants on areas of mutual concern. The Mental Health "System of Care" philosophy and framework over the years have generated research and technical assistance in how to accomplish successful interagency collaboration.
- ☐ IDEA and the Elementary and Secondary Education Act (ESEA) support collaborative efforts among all agencies on behalf of all children, including infants, toddlers, preschoolers and youth. Both laws encourage early identification and intervention.
- ☐ State mental health and education agencies often control or have access to significant funding streams, such as general and special education grant initiatives, Medicaid, state general revenues, federal mental health block grant and other grant programs. Carefully planned and coordinated utilization of these multiple funding streams could help improve the whole child-serving system.
- ☐ Many states and communities have policies in place that establish interagency groups at the state and local levels.
- ☐ Some states have statutes that support or mandate interagency collaboration and joint or interagency funding to develop a shared agenda among child-serving agencies and families.

SOME MAJOR CHALLENGES:

- ☐ Oftentimes, because each system is so invested in its own mission, there is little attention or value placed on the difficult work of building a shared agenda with other agencies or organizations.
- ☐ In spite of improvements, there is still a lack of data and information on what we are doing, how much it costs, and the outcomes of interagency collaboration.

- Different federal agencies with common missions and goals often have not examined their respective authority and alignment. This often results in fragmented efforts at the state and local levels. Strict categorical funding often creates barriers to partnering creatively.
- Many state and local agency policies do not support interagency collaboration.
- Policy at some state and local levels is practiced inconsistently and the infrastructure for developing a shared agenda is weak.
- Even when collaborative policies are in place, turnover of key players and stakeholders can threaten the infrastructure.
- Services to infants, toddlers, and preschool children are often not linked to the full range of prevention and intervention services.
- Provision of services to young children is often not well coordinated with provision of services to older children.

Legal matters

SOME MAJOR STRENGTHS:

- Proactive legal analysis and sharing of information can help in developing a shared agenda.
- Client confidentiality has been successfully addressed in many interagency partnerships; it need not be a barrier to working together.
- Litigation often can be avoided when all partners are working together on behalf of children and youth; however, when necessary, litigation helps to affirm the rights of people and to develop resources so that agencies can carry out their duties to the intended beneficiaries.

A MAJOR CHALLENGE:

- Fear of liability and litigation can interfere with risk-taking and making positive changes.

Advocacy

SOME MAJOR STRENGTHS:

- Effective family advocacy for services and supports for children, youth and families can move and change systems, empower families and inform and support good policy and practices. Legislators are more responsive to their constituents than to agency bureaucrats.
- Self-advocacy is a right that is increasingly claimed by youth and families. Effective partnerships can provide a forum to resolve difficulties around self-advocacy and reduce costly and antagonistic litigation.

Some major challenges:

- Advocacy can be counterproductive to build a shared agenda if it is based only on narrowly conceived self-interest.
- Strong competition among special-interest groups and organizations can be divisive and counterproductive to developing a comprehensive shared agenda. Indeed, an unintended result of advocacy from special interest groups may help perpetuate categorical funding ("silos") of programs within service-delivery systems, which often inhibits the development of a shared agenda.

Leadership

Some major strengths:

- Together, committed and skilled agency and family leaders with vision, passion and relationship-building skills can create a shared agenda. Moreover, they influence and model effective collaboration for their own agencies or organizations.
- Strong leadership in the advocacy community can promote and support an effective shared agenda.

Some major challenges:

- Leaders of key agencies or organizations who are uncommitted to the partnership, or who lack leadership skills, can seriously inhibit effective partnering. Their lack of commitment adversely affects collaborations at all the organizational levels below them.
- Bureaucracies often encourage risk-avoidance behavior.

Capacity Building

Some major strengths:

- A number of federally funded projects have developed excellent curricula and training programs for cross-training personnel from multiple agencies on whole school approaches to meeting the social-emotional and mental health needs of all children.
- Institutions of higher education can become valuable resources in developing and implementing a shared agenda, through ongoing research and training.

Some major challenges:

- Schools and mental health agencies face serious difficulties recruiting and retaining enough qualified and well-trained staff, especially in rural areas.
- Colleges and universities do not provide enough state-of-the art training and education to educators, mental health workers and other service providers on meeting the social-emotional and mental health needs of children, youth and families.
- Institutions of higher learning still do not sufficiently address interagency collaboration as a research interest.

Building a Common Conceptual Framework

Common frameworks help shape policy in consistent, congruent and cohesive ways. Successful intervention partnerships need to adopt a common conceptual framework for meeting the complex needs of all children, youth and their families. A conceptual framework provides the basis for clearly articulated policy and should drive the implementation of a shared agenda in ways that yield a comprehensive, multifaceted and cohesive continuum of interventions.

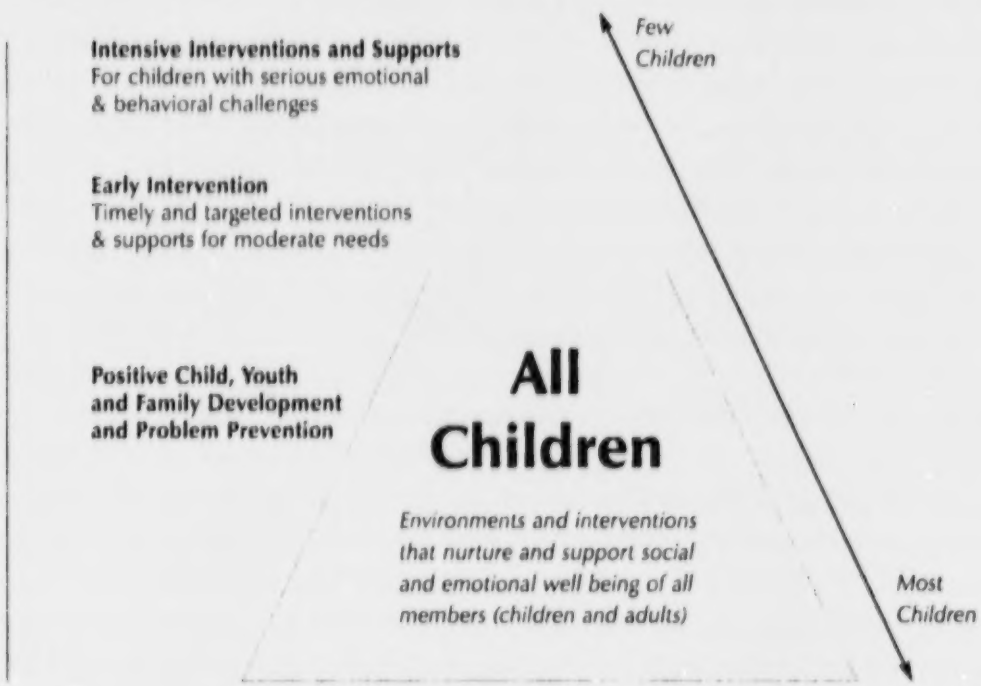
The Foundation of a Shared Agenda: A Common Conceptual Framework

The multi-tiered framework described below is based on a public health model. It provides a comprehensive foundation upon which to build a shared agenda among family organizations and state mental health and education agencies.

A number of initiatives within different federal agencies have adopted the core aspects of this particular public health model. These initiatives use somewhat different language in describing the three major tiers or levels of intervention or activities, but all of them agree on the notion of a continuum of services or systems that is necessary in meeting the social, emotional and mental health needs of all children and youth.

The framework below differentiates three basic levels of intervention: (1) positive child, youth, and family development and prevention of problems; (2) early intervention; and (3) intensive interventions and supports. Descriptions of the three levels follow.

THE MULTI-TIERED FRAMEWORK


Few Children
Intensive Interventions and Supports
For children with serious emotional & behavioral challenges
Early Intervention
Timely and targeted interventions & supports for moderate needs
Positive Child, Youth and Family Development and Problem Prevention
All Children
Environments and interventions that nurture and support social and emotional well being of all members (children and adults)
Most Children

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Positive Child, Youth and Family Development and Problem Prevention

Promoting Positive Development. All systems that support children and youth must be concerned with promoting social-emotional development and learning. This includes parenting and formal programs that teach social and problem-solving skills. It encompasses enrichment and recreation programs, both during school and before and after school. It involves training teachers and staff on how to support positive school and classroom behavior.

Creating and sustaining a supportive environment for children and youth is a community-wide responsibility. The school is a critical part of that environment. Activities that create a sense of community through personal relationships and connections help create safe and supportive environments. School and service agency personnel can model appropriate behaviors, create a climate of emotional support and demonstrate commitment to working with all youngsters. Equally important, personnel must be provided with support and assistance in sustaining a healthy school and service agency climate.

Problem Prevention. Preventing foreseeable and recurring problems include promoting healthy development and safe environments. It also includes creating systems of prevention for all children and families.

Examples of programs to promote positive development and prevent problems are: welcoming and social support programs for new students and their families, values-based alcohol and drug education and support for transitions and child abuse education.

In some schools and communities, the majority of students will require no more than this first level of intervention.

Early Intervention

This level involves addressing emotional and behavior problems children experience at an early age and intervening as soon as a problem occurs, no matter what the age of the child. Examples include small group activities, behavioral support plans, after school programs and dropout re-entry programs.

Intensive interventions and supports

This level includes more intense and sustained services and supports for children who experience severe, persistent, or chronic emotional or behavioral disabilities (about 3-5 percent of all children). These children and youth and their families usually require individualized multidisciplinary and multi-agency service plans to access a coordinated system of care. Examples of strategies within a service plan include intensive home-based services, respite care, individual, group, and family therapy, therapeutic foster care, crisis intervention, intensive after-school programs and in-school aides, all of which are linked through service coordination.

This multi-tiered framework is a helpful way to conceptualize the continuum of services and interventions, and to recognize them as a coherent system. Arguing over whether a particular intervention fits into one level or another is counterproductive. For instance, whether any school-wide activity is "prevention" or "positive youth development" for purposes of our discussion is not as important as understanding that all systems must conceptualize and build a continuum of interventions as complete as possible, from the least intensive and restrictive to the most intensive and restrictive.

Some Federally Supported Initiatives that are Grounded in the Multi-tiered Framework

The multi-tiered framework described is the foundation for a number of federally supported systems change initiatives and programs.

Education

- *"Safeguarding our Children," 2000, Departments of Education and Justice*
- *The Technical Assistance Center on Positive Behavioral Interventions and Supports (PBIS)*
- *The National Center on Education, Disability, and Juvenile Justice (EDJJ)*
- *The Center for Effective Collaboration and Practice (CECP)*

Mental Health

- *"Building Bridges of Support: One Community at a Time," a five-year grant to parts of Appalachian Kentucky under the Comprehensive Community Mental Health Services for Children and Their Families Program, funded by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration*
- *Policy Leadership Cadre for Mental Health in the Schools, "Mental Health in Schools: Guidelines, Models, Resources, and Policy Considerations," 2000*

The Promise of a Conceptual Framework

The multi-tiered framework provides a foundation for mapping policy and program development. It is a commonsense approach that can apply to all programs and services. The framework represents a conceptual shift and grounds a shared vision of systemic interventions that drive the planning and implementation of services directed toward the well being of all children. Moreover, if positive child and youth development, problem prevention and early intervention strategies are in place, and students receive the kind of help they need earlier, fewer children will need intensive interventions.

Using a common and comprehensive framework, mental health and school staff can appreciate and pursue a more integrated role in comprehensive school-wide efforts to meet the social-emotional needs of all students. Mental health workers practice what they know best—conducting psychological evaluations, or individual and group therapy—and too often see little opportunity to address the environment in which they are working. As "insiders," these mental health workers can become knowledgeable about how the school is organized and works, be co-trained with school personnel on school-wide approaches and integrate all their efforts into the school's culture. They will work with the schools to identify and seek intensive mental health services for those students who need them, but they will do so as a part of a school's comprehensive, multi-faceted, and integrated approach for all students.

Education, mental health systems, families and youth can join together. They already are doing so in communities around the nation. Through shared initiatives, they are addressing barriers to learning and improving the lives of all young people. It is time to move to action in every community and school.

Aligning Policy and Practice to Facilitate Effective Partnerships for a Shared Agenda

Policies and practices are key factors in the effectiveness of partnerships. It is important to recognize the different but related interests of each organization.

Education policy focuses the school's critical role in promoting the mental wellness of all students and the role in promoting healthy school climate and improving educational outcomes.

Mental health policy stresses the importance of integrating child and youth development, prevention and early intervention programs and services into the natural settings of children and youth, in addition to providing services and programs for children and adolescents with emotional disturbances. This emphasis on prevention and early intervention can enhance community-wide mental wellness and reduce costs by reducing the numbers who need the much more expensive interventions required for treating severe emotional disturbances.

In general, state agencies might seek to align policies within an agency and among agencies through review teams composed of local and state professionals, family members and community partners. While resulting polices and practices will not be identical, they may become more consistent with the agencies' values and principles.

Among the first steps that education and mental health agencies might take to align policies that will eventually support practice are:

- **Identify common values and goals:** Agencies should strive to ensure that the social-emotional and mental health needs of all children and youth are met with the least intrusive activities and interventions, in the least restrictive setting, at the earliest possible time. A strong emphasis should be placed on practices that build on the strengths and competencies of all children, staff, families and other community stakeholders.
- **Commit to family-centeredness:** Reinforce the responsibilities of child-serving entities to:
  - Support the integrity and unity of the family
  - Provide mechanisms to ensure family-centered services
  - Acknowledge and utilize the family's cultural strengths
  - Design and implement systems that empower the participation, planning and decisionmaking by families
- **Design integrated training:** Facilitate the joint development and implementation of comprehensive and coordinated curricula for all partners. These curricula should include core competencies for all and specialized skills for each of the components of the multi-tiered framework. Cross-train all partners in core competencies as much as possible.

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- **Pursue shared accountability:** Ensure a joint accountability system that identifies and measures desired outcomes, tracks costs, and improves effectiveness and efficiency of the collaborative efforts. Facilitate the sharing of individual, aggregate and system information across systems, while assuring appropriate confidentiality for children, youth and their families.
- **Coordinate funding and budgeting:** Enable the development of a coordinated budgeting process that ensures that partners maximize all funding sources and eliminate waste and duplication of effort.
- **Create flexibility that supports local initiatives:** Through waivers and other means, make efforts to allow for local agency creativity in designing and implementing best practices.

Note: *The collaborative approach and the multi-tiered framework promoted in this Concept Paper are intended to include all state and local child-serving partners. In addition to education and mental health agencies and family organizations, it is directed toward public health services, child welfare, juvenile justice, family resource and youth service centers, faith-based organizations, private service and recreational organizations, and other interested groups. This Concept Paper focuses on the relationships among families and youth and public mental health and education systems. This does not mean to imply that these partners are the only possible ones. Depending on the current political, fiscal and other circumstances in a particular state, any number of key agencies or organizations can begin the kind of work needed to realize this vision.*

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IV. Recommendations for Immediate Action

The following recommendations are formulated in terms of action steps that will be initiated through NASMHPD and NASDSE. These two national organizations represent individuals who have the influence and authority within states to introduce change. Through their interaction in The Policymaker Partnership, these two groups can shape national discussions while forging action initiatives and engaging other important stakeholders at the state level. Collectively, their efforts may allow states to reconceptualize their relationship with the individuals and families that are the consumers of their service. As well, their efforts should enable a shared agenda across agencies. Toward this end, the advisors to this document recommend that NASPHPD and NASDSE work through the Policymaker Partnership and the IDEA Partnerships to:

A. **Initiate the process for implementing the recommendations: *Establish and maintain a national cross-sector advisory body.***
After a planned national dissemination of this document, NASMHPD and NASDSE should maintain communication among the members of the Concept Paper task force for the purpose of advising states and national organizations as requested.

B. **Identify and convene teams from interested states.**
NASMHPD and NASDSE should convene cross-sector teams from states that wish to pursue the vision presented in this document. These teams will become a work group focused on these issues. Their work will inform each other and the national organizations and agencies in their related fields. Each state will identify the ways in which the cross-sector teams will work to support this vision within their state framework.

NASMHPD and NASDSE should support states in:

- ☐ Identifying ways in blending and braiding resources in support of a shared agenda. Blending of funds imply that funds are mixed for a common purpose and lose their categorical identity. Braiding implies that resources dedicated to address similar concerns are woven together to strengthen each other's efforts.
- ☐ Developing of a "change agent" mindset throughout the cross-sector teams.
- ☐ "Bridge building" strategies that link the state agencies with the local agencies in actualizing a shared agenda.

- Creating durable partnerships, including alignment of missions, policies and practices across agencies, shared accountability, resource mapping, redeployment of existing resources, and action planning.
- Facilitating communication, coordination, problem solving, and sharing of lessons learned.
- Initiating capacity building efforts, including cross-training, that have potential to move the shared agenda beyond demonstration sites and develop efforts at scale across the states.
- Adopting strategies that develop leadership across systems at all levels.

C. Engage and involve the researchers and technical assistance providers in education, special education and mental health.

Each agency makes research investments that provide information that is essential in guiding system decisions. Each agency also supports a network of providers that assist state systems in making and sustaining change. In each organization family groups are active in bringing information to the consumers. It is important to involve these researchers, providers and family groups as they play key roles in system change efforts at the national, regional, state and local levels.

V. Concluding Statement

For over a decade policymakers, educators, mental health personnel and families have recognized that both academic and non-academic barriers threaten school achievement and community participation. Education and well being are interrelated. Healthy families support school performance. Likewise, school success helps families and supports the goals they and their children have set. Today's families are challenged by a number of complex problems. They have a variety of needs. Today's schools share an interest in seeing that those needs are met. For these reasons, policy in education, health and mental health have encouraged co-operation, collaboration, cost sharing and, in some cases, consolidation of services.

Beginning with a commonly accepted, multi-tiered framework, partners can forge a shared agenda to which they will commit their work and their resources. Achieving the promises of this shared agenda requires true commitment. Partners must believe that the payoff in better outcomes for children, youth and their families is worth the investment of time, energy and money.

A number of highly successful state and community initiatives demonstrate that such investments are indeed worthwhile. Given the promise of enhanced partnerships, it is time to align policy and practice across agencies and move forward together.

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Appendix A. Development of the Concept Paper

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Appendix B. Resources for Mental Health in Schools

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Appendix C. The Dimensions of an Accountability Framework

***As developed by the Mental Health Workgroup** (in rank order)*

All potential partners in a shared agenda for children, youth and their families must be concerned about accountability for resources and outcomes. Education and mental health agencies and family organizations should develop a shared accountability framework. Here are some key dimensions of an accountability framework that should be addressed:

1. **Move toward aligned missions and shared outcomes.**

   Within this dimension, building consensus on outcomes meaningful to all stakeholders is an important aspect. Additionally, understanding the interconnectedness of outcomes (e.g., improved academic outcomes are connected to improved emotional functioning) is vital. Without acknowledgement of this interdependency, all systems fail to reach desired outcomes. A leadership summit could begin this process and actions, agreements and mechanisms across systems could be developed through such a process.

2. **Develop a mechanism for children, youth and families and ensure that it is inclusive of all systems.**

   A mechanism or team should be established to help guide all child-serving agencies, including children, youth and families, to develop shared outcomes and to monitor their achievement on an on-going basis.

3. **Improve communication and problem-solving mechanisms across systems.**

   Enhanced communication between and among key stakeholders (including state policymakers, children, youth and families, local policymakers and community leaders, university personnel) is critical to a functional accountability framework. Without establishing such communication mechanisms, systemic change will not be achieved at all levels.

4. **Ensure compatibility in accountability mechanisms across systems and connect resources to performance.**

   The promotion of common and shared indicators is important both to a shared vision across systems and to achieving desired outcomes. Growth and progress toward identifying and then achieving positive indicators should be linked to providing additional resources to programs and initiatives that assist in achieving these outcomes.

5. **Align and/or develop resources to achieve outcomes identified through the accountability mechanisms.**

   While coordinating services, explore mechanisms for braiding funds, resources and staff that allow agencies and programs to maintain integrity while pursuing common indicators. These mechanisms will help personnel maintain unique roles and skills while joining forces to achieve common outcomes.

6. **Ensure that accountability mechanisms are unbiased and influential.**

   Integrity of the accountability framework is essential for its effectiveness. Quality assurance mechanisms must be in place to promote productive and valid team decisionmaking. State leadership in all systems should be kept apprised of all emerging themes, activities and accomplishments of the collaborative efforts.

7. **Publicize and market the work and outcomes of the accountability framework. Increase public participation in and awareness of improved outcomes brought about by systems change.**

   Use all potential media outlets, including public dialogue, newsletters and reports, to publicize cross-systems accomplishments and outcomes.

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